DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-001

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Sectin 1902(a)(13) and 1902(a)(30) of the Act; ~~42 CFR 447.250 through 447.272~~

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 20.1M
b. FFY 2001 $ 12.36M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

RECEIVED
HCFA-DMSO
2000 MAR 31 PM 2:49

10. SUBJECT OF AMENDMENT:
Nursing Facility Services Payment Methodology

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED ~~WITHIN 45~~ DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mark E. Reynolds

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
March 31, 2000

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 31, 2000

18. DATE APPROVED:
May 7, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
ARA, DMSO, Boston Region

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MASSACHUSETTS MEDICAL ASSISTANCE PROGRAM

Methods Used to Determine Rates of Payment for Nursing Facilities

I. GENERAL DESCRIPTION OF PAYMENT METHODOLOGY

A. Overview: Nursing facility payments for services rendered to publicly-assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard **Payments to Nursing Facilities**. The following sections in this attachment describe the methods and standards used to establish payment rates for nursing facilities effective *January 1, 2000.*

B. Chief Components: The payment method, described below, continues the shift away from historical facility specific cost-based reimbursement to standard payments for nursing facility services. The payment method contains a blend of facility-specific costs and standard payment rates for Nursing and Other Operating Costs, as well as payment rates for Capital. Nursing and Other Operating rates were calculated using FY 1998 updated by a CAF of 4.78%. The allowable basis for capital was updated using FY 1998 data. For Rate Year 2000, there continue to be several transition adjustments to ease the transition to standard payments.

II. COST REPORTING REQUIREMENTS AND COST FINDING

A. Required Reports: Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are three (3) reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; and Management Company Cost Report. All cost reporting must meet the requirements set forth in Appendix A (114.2 CMR 6.07 (2) pg. 16). There are special cost reporting requirements for Hospital Based Nursing Facilities and facilities which operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in Appendix A (114.2 CMR 6.07 (2)(f) p. 17- 18).

B. Filing Dates: Reports: Except as provided below, Providers must file the required Cost Reports for the calendar year by 5:00 PM of April first of the following calendar year. If April 1 falls on a weekend or holiday, the Reports are due by 5:00 PM of the following business day.

1. Change of Ownership. Where there has been a change of ownership, the transferor shall file the Report(s) within sixty (60) days after the transfer of ownership. Where the transferor fails to submit the Report(s), the Division of Health Care Finance and Policy may request the Division of Medial Assistance to withhold payment to the transferee until such reports are appropriately filed.

2. New Facilities and Facilities with Major Additions. For the first two calendar years of operation, New Facilities and Facilities with Major Additions shall file year-end Cost Reports within sixty (60) days after the close of the calendar year.

3. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility that is licensed for both hospital and long-term-term care services, where the long-term-term care beds were converted from

licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Report(s) on a fiscal year basis that is consistent with the filing of such facilities' hospital cost reports. The Report(s) is due no later than ninety (90) days after the close of the facility's fiscal year.

4. Termination of Provider Contract. Whenever a provider contract between the provider and the Division of Medical Assistance is terminated, the provider shall file Reports covering the current reporting period or portion thereof covered by the contract and any other Reports required by the Division of Health Care Finance and Policy, within sixty (60) days of such termination. When the provider fails to file the required Reports in a timely fashion, the Division of Health Care Finance and Policy shall notify the provider of this failure by written notice sent registered mail, return receipt requested

5. Appointment of Patient Protector Receiver. If a receiver is appointed pursuant to court order under M.G.L. c. 111, s. 72N, the provider must file Reports for the current reporting period or portion thereof within sixty (60) days of the receiver's appointment.

C. Filing Extensions: The Division of Health Care Finance and Policy may grant an extension, up to forty-five (45) calendar days, for submission of the Report(s). A request for an extension must: (a) be submitted in writing to the Division of Health Care Finance and Policy by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. Incomplete Submission: The Division of Health Care Finance and Policy shall notify the provider within one hundred twenty (120) days of receipt of the Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with the Division of Health Care Finance and Policy within twenty-five (25) days of the date of notification or by April 1 of the year the Report is filed, whichever is later. The Reports and all accompanying schedules is deemed to be filed with the Division of Health Care Finance and Policy as of the date the Division of Health Care Finance and Policy receives complete submission.

If the Division of Health Care Finance and Policy fails to notify the provider within the 120-day period, the submission is considered complete and the Report(s) and all accompanying schedules is deemed to be filed with the Division of Health Care Finance and Policy as of the date of receipt.

E. Audits: The Divisions of Health Care Finance and Policy and Medical Assistance may conduct desk or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any related party as requested, even if the Division of Health Care Finance and Policy has accepted such Provider Cost Reports.

F. Penalties for Failure to File Timely: A provider's rate for current services will be reduced in accordance with the formula contained in 114.2 CMR 6.07(8) (Appendix A, p. 20) if the required Cost Reports are not filed in a timely manner. On receipt of such cost reports, the Provider's rate will be restored effective on the date of report filing.

G. General Cost Principles: In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

1. The cost is ordinary, necessary and directly related to the care of publicly aided

patients;
2. The cost is for goods or services actually provided in the nursing facility
3. The cost must be reasonable; and,
4. The provider must actually pay the cost. Costs which are not considered related to the care of Medicaid patients include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates.

A provider may not report any of the costs that are listed in 114.2 CMR 6.07 (2) (e) (Appendix A, p. 19) as related to Medicaid patient care.

III. METHODS AND STANDARDS USED TO DETERMINE PAYMENT RATES

A. Prospective Per Diem Rates: The prospective per diem payment rates for nursing facilities are derived from several components: Nursing, Other Operating, Capital, RY 2000 Transition Payments, and a Total Payment Adjustment. Each of these components is described in detail in the following sections.

B. Nursing Cost. The Nursing cost component consists of a blend of facility-specific costs and standard payments, as follows:

1. Allowable Nursing Costs: Facility-specific allowable nursing per diem costs are computed in accordance with 114.2 CMR 6.03(2) (a) (1) (Appendix A, pp. 5- 6), using reported 1998 nursing costs and 1998 management minutes and subject to a cost adjustment factor of 4.78% (1998-2000). The cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

2. Standard Payments for Nursing: The base year used to develop the Nursing Standard Payments is 1998. Nursing costs reported in 1998 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The Nursing Standard Payments are derived from the product of the industry 1998 median nursing costs times the 1998 industry median management minutes for each of six (6) payment groups listed in 114.2 CMR 6.03(1) (Appendix A, p. 5). The base year amounts for each group are updated to rate year 2000 by a cost adjustment factor of 4.78% This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by DRI.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 - 30	$ 9.81
JK	30.1 - 110	$ 21.96
LM	110.1 - 170	$ 46.43
NP	170.1 - 225	$ 64.74
RS	225.1 - 270	$ 81.28
T	270.1 & above	$ 98.66

3. Calculation of Nursing Rate Component: For five of the Payment Groups JK to T, the Nursing rate component is the higher of: (a) the sum of 33.3% of the Allowable Nursing Per Diem Costs and 66.7% of the Nursing Standard Payments; or, (b) the sum of 50% of the Allowable Nursing Per Diem Costs and 50% of the Nursing Standard Payments. For

Payment Group H, the Nursing Standard Payment is used.

C. Other Operating Cost. The Other Operating Cost component consists of a blend of facility-specific costs and standard **payments as follows:**

1. Allowable Other Operating Costs: Allowable other operating per diem costs for each nursing facility are computed in accordance with 114.2 CMR 6.04(2) (a) (Appendix A, pp. 6-7), using reported 1998 operating costs, subject to a ceiling on administrative and general costs of $11.48 per diem and an overall ceiling of $54.14 (industry median plus 6%), and increased by the cost adjustment factor of 4.78% (1998-2000). The cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

2. Standard Payment for Other Operating: The base year used to develop the Other Operating Standard Payment of $53.52 is 1998. Other operating costs reported in 1998 in the following categories are included in the calculation: variable, administrative & general, and motor vehicle costs. The Other Operating Standard Payment is set equal to the 1998 industry median of these cost amounts, except for Administrative & General costs which are subject to a ceiling of $11.48 before combining with other cost components. The 1998 amount is updated to rate year 2000 by a cost adjustment factor of 4.78%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as nation and regional indices supplied by DRI.

3. Calculation of Other Operating Rate Component: For five of the Payment Groups JK to T, the other operating rate component is the higher of: (a) the sum of 33.3% of the Allowable Other Operating Per Diem Costs and 66.7% of the Other Operating Standard Payment; or, (b) the sum of 50% of the Allowable Other Operating Per Diem Costs and 50% of the Other Operating Standard Payment. For Payment Group H, the Other Operating Standard Payment is used.

D. Capital: The Capital component is computed in accordance with 114.2 CMR 6.05 (2) (Appendix A, pp. 8-11), using the allowable depreciation, financing contribution and other fixed costs based on the allowable basis of fixed assets as of December 31, 1998.

1. Determination of RY 200 Capital Payments
   a) If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is greater than $17.29, its 2000 Capital Payment will be $17.29.
   b) If the Provider's 1999 Capital Payment is lower than $17.29, and its Capital Cost per diem is lower than $17.29, its 2000 Capital Payment will be its Capital Cost per diem.
   c) If the Provider's 1999 Capital Payment is greater than or equal to $17.29, and its Capital Cost per diem is greater than $17.29, its 2000 Capital Payment will be the greater of $17.29 or 90% of its Capital Cost per diem.
   d) If the Provider's 1999 Capital Payment is greater than or equal to $17.29, and its Capital Cost per diem is lower than $17.29, its 2000 Capital Payment will be its Capital Cost per diem.
   e) If a Provider re-licenses beds in 2000 which were out of service, its 2000 Capital Payment will be the lower of $17.29 or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.

2. Capital Payment Exceptions: For the following facilities that meet the criteria in 114.2 CMR 6.05 (1) (Appendix A, pp. 7- 8), the Capital component for rate year 2000 is $17.29:

a) New Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
b) Replacement facilities that open pursuant to a Determination of Need approved after March 7, 1996;
c) New Facilities in Urban Underbedded areas that are exempt from the Determination of Need process;
d) New beds that are licensed pursuant to a Determination of Need approved after March 7, 1996;
e) New beds in twelve-bed expansion projects not associated with an approved Determination of Need project;
f) Hospital-Based Nursing Facilities; and
g) Private Nursing Facilities that sign their first Provider Agreement in 2000.

3. Notification of Substantial Capital Expenditures. Any nursing facility which opens in 2000 or adds new beds or adds substantial renovations in 2000 or re-opens beds is required to notify the Division of Health Care Finance and Policy in accordance with 114.2 CMR 6.05(3) (a) (Appendix A, p.11). At that time, the Capital component may be recomputed in accordance with 114.2 CMR 6.05(3) (b) (Appendix A, p.11- 12).

E. 2000 Transition Payments:

1. Add-on for Certified Nursing Assistants: An add-on is computed in accordance with 114.2 CMR 6.06 (1) (c) (1) (Appendix A, pp. 13) for the purpose of funding increases in the staffing, salaries and benefits of Certified Nursing Assistants. The Division of Health Care Finance and Policy to verify whether the add-on is expended as intended will conduct a retrospective review of the add-on. If a nursing facility does not expend the add-on for Certified Nursing Assistants as intended, an overpayment amount will be determined in accordance with 114.2 CMR 6.06 (1) (c) (2) (Appendix A, pp. 13-14).

3. Supplemental Add-on for Survey Performance: An add-on of $0.25 per diem is computed in accordance with 114.2 CMR 6.06(1)(d) (Appendix A, p. 14) where a nursing facility received a perfect score of 132 from the Department of Public Health on the most recent Survey Performance Tool for Nursing Facilities.

F. Total Payment Adjustment: A total payment adjustment is applied to the payment rates. The total payment adjustment is computed in accordance with 114,2 CMR 6.06(1)(b) (Appendix A, pp. 12-13) to buffer the impact of changes in rate methodology from prior years. According to the formula, all rate changes from the prior year are moderated within the range of 0- 6%.

G. Rate Year Adjustments: Adjustments to rates will occur in the following circumstances:

1. Retroactive Adjustments: The Division of Health Care Finance and Policy will retroactively adjust rates according to 114.2 CMR 6.06(2) (Appendix A, p. 14-15) in the following situations: Facilities which did not file a 1998 Cost Report, Amended Rates for Prior Years, *Mechanical Errors, and Errors in the Cost Reports.*

2. Medicare Upper Limit of Payment: No weighted average prospective rate of payment established under 114.2 CMR 600 et seq. (**Appendix A**) shall exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement. An adjustment will be made only to the extent the costs are reasonable and attributable to the circumstances specified under the Medicare principles and separately identified and verified by the provider.

IV. Special Conditions

A. Rate for Innovative and Special Programs: The Division of Medical Assistance may contract for special and/or innovative programs to meet special needs of certain patients which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e. Management Minute Category T).

B. A provider who seeks to participate in an innovative and special program must contract with the Division of Medical Assistance to provide special care and services to distinct categories of patients designated by the Division of Medical Assistance. This is usually done through a Request for Proposals by the Division of Medical Assistance for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Reimbursement under the innovative and special programs may be calculated based on the added allowable actual costs and expenses that must be incurred (as determined by the Division of Medical Assistance) by a provider in connection with that program. However, it still must be consistent with the payment methodology established for long-term care facilities. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the Medical Assistance Program, and that such items or services are necessary in the efficient delivery of necessary health care. These costs will be added as an increment to the facility's rate in establishing a rate for an innovative and special program. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

C. A facility that has recently converted from a facility providing non-acute hospital services to a facility providing nursing facility services may be reimbursed as a special program. In order to be considered as a special program, such a facility must agree to provide, or arrange and pay for, all Medicaid covered services, except hospital services, to all Medicaid recipients that are residents of the facility. The reimbursement to such facilities is a per diem rate which is the facility's regular case mix rates with an add-on which is based on the reasonable costs of providing the goods and services beyond those required to be provided by nursing facilities.

D. A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board; and,

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to quality for MM category 10; and,

3. the facility must be a geriatric nursing facility.

E. **Pediatric Nursing Facilities:** Payments will be determined using 1998 reported costs for Nursing and Other Operating Costs, excluding Administration and General Costs. Administration and General Costs will be subject to a cap of $ 11.48.

F. Pilot Program for Ancillary Costs: Nursing facilities that applied to the Division of Medical Assistance to participate in an alternative Ancillary Pilot Program for payment of Ancillary services may receive incentive payments. Participation is voluntary, subject to approval by the Division of Medical Assistance. **Appendix E.** contains the payment methodology for incentive payments that may be made to the providers who participated in the voluntary Ancillary Pilot Project commencing in December 1, 1998.

G. Beds Out of Service: Facilities with licensed beds that were out of service prior to 1998 which re-open in 2000 will receive the lower of the Standard Payment rates or the most recent prior billing rates inflated to 1997 for Nursing and Other Operating Costs.

H. Legislative Mandate for Rate Relief: A nursing home (i) with rate of public utilization, consisting of Medicare, Medicaid and Commission for the Blind patients, of ninety percent or more, (ii) located in the service area of a federally designated sole community hospital, and (iii) with more than 10% of its variable costs and nursing costs disallowed by the Division of Health Care Finance and Policy pursuant to 114.2 CMR 5.00 or any successor regulation, shall have all of its variable costs and nursing costs recognized by the Division of Health Care Finance and Policy and its Medicaid rate adjusted accordingly. The Division of Health Care Finance and Policy shall adjust the prospective rates for any such nursing home that meet the aforementioned criteria for the rates that were effective January 1, 1994 and for each succeeding rate year that such nursing homes comply with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by the Division of Health Care Finance and Policy for any rate for a nursing home is limited to an amount that will not increase costs to the Medical Assistance program in an amount greater that three hundred thousand dollars. Not withstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to February 1. 1998.

Any nursing facility that meets either the standards set forth in **(a) or (b)** below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the Division of Medical Assistance calculates the facility's payment rates. This provision shall only apply to services rendered on or after February 1, 1998.

(a)

- the owner purchased the nursing home on or after January 1, 1987;
- the owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;
- the owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts which is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital which is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health;
- the owner's patient population is, on average, not less than eighty-five percent (85%) Medicaid recipients;

- the Hospital has, on average, not less than eighty percent (80%) occupancy of medical or surgical beds;

- when the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization which is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder or administrator of the owner by common ownership or control or in a manner specified in section 267(b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing, or refinancing: or

(b)

- the owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the acute care hospital conversion board pursuant to M.G.L. c.6A, s.101;

- the acute care hospital conversion board approved the owner's acquisition costs of the facility; and,

- on average, no less than eight-five percent (85%) of the nursing facility's patient population are Medicaid recipients.

I. Notwithstanding anything to the contrary contained in this State Plan, any nursing home that is owned by the Martha's Vineyard Hospital Foundation during the time that said Foundation also administers a federally designated sole community provider hospital shall have allowed all of its extra variable and fixed costs that reasonably result from such nursing home being located in a geographically isolated area.

J. Receivership Under M.G.L. c.111 s.72N et seq. (see Appendix C); The prospective rates of a nursing facility in receivership may be increased by an appropriate per diem amount to reflect the reasonable costs associated with the court-approved closure of the facility.

K. Review and Approval of Rates and Rate Methodology By The Division of Medical Assistance: Pursuant to M.G.L. c 118E, s.13 (see Appendix D) the Division of Medical Assistance shall review and approve or disapprove, any change in rates or in rate methodology proposed by the Division of Health Care Finance and Policy. The Division of Medical Assistance shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the Division of Health Care Finance and Policy; provided that, the Division of Medical Assistance shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the Massachusetts House and Senate Committees on Ways and Means. The Division of Medical Assistance shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the Division of Health Care Finance and Policy together with such recommendations for changes. Such disapproval and recommendations for changes, if any, is submitted to the Division of Health Care Finance and Policy after the Division of Medical Assistance is notified that the Division of Health Care Finance and Policy intends to propose a

rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the Division of Health Care Finance and Policy regarding such rate change; provided that no rates shall take effect without the approval of the Division of Medical Assistance. The Division of Health Care Finance and Policy and the Division of Medical Assistance shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.

L. The Division of Health Care Finance and Policy shall supply the Division of Medical Assistance with all statistical information necessary to carry out the Division's review responsibilities under this Section. Not withstanding the foregoing, said Division of Medical Assistance shall not review, approve, or disapprove any such rate set pursuant to Chapter twenty-three of the Massachusetts Acts of Nineteen Hundred and eighty-eight.

M. If projected payments from rates necessary to conform to applicable requirements of title XIX are estimated by the Division of Medical Assistance to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the Division of Medical Assistance and the Division of Health Care Finance and Policy shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the Division of Medical Assistance under Title XIX of the Federal Social Security Act.

N. Appeals: A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division of Health Care Finance and Policy files the rate with the State Secretary. The Division of Health Care Finance and Policy may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

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OFFICIAL

Appendix E.
Division Medical Assistance
Bulletin 115
Ancillary Pilot Project

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

MassHealth
Nursing Facility Bulletin 115
August 1998

TO: Nursing Facilities Participating in MassHealth

FROM: Bruce M. Bullen, Commissioner

RE: **Voluntary Ancillary Pilot Project**

Introduction

The Division is conducting a voluntary pilot project. The project will study the inclusion of ancillary goods and services in nursing-facility per diem rates. The purpose of this bulletin is to describe how the voluntary ancillary pilot will be conducted.

Informational Sessions

The Division of Medical Assistance, in collaboration with the Division of Health Care Finance and Policy and the Massachusetts Extended Care Federation (MECF), will be holding three statewide informational meetings. **Please contact MECF at (617) 558-0202 to register for one of the following sessions and for directions.**

Tuesday, August 25, 1998 *10:00 a.m. to 12:00 p.m.*	*Willows at Westborough,* *1 Lyman St.* *Westborough, MA*
Wednesday, August 26, 1998 *10:00 a.m. to 12:00 p.m.*	*Mass. Extended Care Federation* *2310 Washington St.* *Newton Lower Falls, MA*
Thursday, August 27, 1998 *10:00 a.m. to 12:00 p.m.*	*Elihu White Nursing and Rehab. Ctr.* *95 Commercial St.* *Braintree, MA.*

Objectives

The main objectives of the voluntary pilot project are to:

1. collect information to enhance the Division's understanding of how best to include ancillary goods and services into fully bundled nursing facility rates; and
2. assess what accommodations may be needed to ensure access to adequate and appropriate service levels for MassHealth members.

Overview

The ancillary pilot project will:

1. determine for each participating facility a per diem Medicaid ancillary cost per day based on state fiscal year (SFY) 1996 ancillary claims payments, inflated for the pilot period during SFY 1999. Throughout the remainder of this bulletin this amount will be referred to as the facility specific rate (FSR);
2. utilize a statewide standard payment per day for ancillary goods and services. The statewide standard payment per day (SSPD) equals $5.85;
3. pay a participating facility based on a risk/return model (Risk/return sharing between the facility and the Division will be in the form of a retrospective settlement considering the prospective ancillary allowance and the actual amount expended by the Division in payments to ancillary vendors.);
4. exclude from retrospective settlement calculation any patient with ancillary spending per patient day in excess of 500% of the statewide-average ancillary-per-diem payment for the period of the pilot project;
5. reconcile each facility's final payments at the end of the pilot project;
6. allow ancillary vendors to continue to bill the Division directly; and
7. make available for each participating facility monthly updates on ancillary spending.

Payment

A facility chosen to participate in the pilot project will be assigned to one of two payment groups depending on their FSR. (Please refer to Attachment A to determine the payment model for your facility) The groups are as follows:

1. Group I, Standard Payment Model: A facility will be assigned to this group if their FSR falls between the statewide standard of $5.85 and $7.02 (120% of $5.85).
2. Group II, Outlier Payment Model: A facility will be assigned to this group if their FSR falls either between $1.17 (20% of $5.85) and $5.85 or between $7.02 (120% of $5.85) and $11.70 (200% of $ 5.85). Facilities with spending levels less than $1.17 or greater than $11.70 are excluded from participation in the pilot project.

Billing

For administrative simplicity, vendors of ancillary goods and services will continue to submit claims to the Division directly, and the Division will continue to process these claims for payment.